Introduction

The Arizona Workers' Compensation Act ("Act") requires that an employer promptly provide reasonably required medical, surgical, and hospital benefits to an injured employee who has sustained a compensable injury. The implementation of a process for the use of treatment guidelines, which is required under A.R.S. § 23-1062.03, is intended to improve the quality and outcomes of medical care, and to improve the efficiency and effectiveness of the process under which that medical care is provided to the injured employee. This would include reducing delays in providing employees with reasonably required medical treatment and improving the processing of their workers' compensation claims. To that end, all parties are encouraged to participate in the Fast Track Dispute Resolution Program under Section IV in cases where hearings are requested under this process.

Unless otherwise stated, the process described below is not intended to change, affect, or alter the legal status and obligations of the treating physician and injured employee with respect to medical treatment and services provided under the Act. Additionally, while this process does not apply to a payer's decision to deny a request for pre-authorization for medical treatment or services for a non-medical reason, a payer is still required to reasonably and promptly communicate its decision with respect to such requests.

The Act also requires that a payer pay for medical treatment or services reasonably required to treat body parts/conditions that have been accepted as compensable. No pre-authorization is required under the Act to ensure payment for reasonably required medical treatment or services. While pre-authorization is not required under the Act, a provider has the option to seek pre-authorization. In this situation, the process described below applies only with respect to a request for pre-authorization to provide treatment or services for the management of chronic pain and for the use of opioids for all stages of pain management. Under this process, medical treatment or services is considered reasonable and correct when supported by the adopted guidelines or a deviation from the adopted guideline is justified.

Successful implementation of the process described below also requires timely decisions and effective communication between all participants. The responsibility for clear and timely communication and documentation rests with all participants involved in the process. Notwithstanding specific timeframes/requirements contained within the process, participants should strive to accommodate and work cooperatively with each other throughout the process, which includes communicating decisions promptly within a reasonable amount of time. With regard to requests for pre-authorization, the expectation is that, in most cases, a payer should be able to communicate a decision regarding a non-urgent or non-life-threatening condition within 5 business days. A payer should be able to communicate a decision regarding an urgent or life-threatening condition within 72 hours.

I. General Provisions

A. The ICA shall provide administrative review and oversight of this process.

B. The guidelines adopted by the ICA (guidelines) shall only apply to the management of chronic pain and the use of opioids for all stages of pain management. For purposes of this process, chronic pain shall be defined by the guidelines.

C. This process applies to all claims filed with the Commission effective xx-xx-xxxx.

D. The guidelines shall apply prospectively. Any recommended limits provided in the guidelines apply to treatment occurring on or after the effective date of this process.

E. This process only applies to treatment and services for body parts/conditions that have been accepted as compensable.

F. Use of the guidelines is mandatory in the management of chronic pain and in the use of opioids for all stages of pain management. The guidelines are to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The guidelines set forth care that is generally considered reasonable and they are rebuttably presumed correct if the guidelines provide recommendations related to the requested treatment or service. Reasonable medical care, however, may include deviations from the guidelines. To support such a request, the provider must produce documentation and justification that demonstrates by a preponderance of credible medical evidence, a medical basis for departing from the guidelines. Credible medical evidence may include clinical expertise and judgment.

G. Denial of Pre-authorization

1. A payer shall not deny a request for pre-authorization solely because the guidelines do not address the requested treatment or services.

2. A payer shall not deny a request for pre-authorization that is supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a contraindication or significant medical or psychological reason not to authorize the requested treatment or services. Upon request by the provider or injured employee, a denial of pre-authorization in this situation shall be processed as an immediate referral to the Commission for administrative review as provided in Section III unless the payer obtains an Independent Medical Examination ("IME"). If the payer obtains an IME which serves as the basis for the

denial, review of the decision shall be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by the injured employee.

H. Denial of Payment for Provided Treatment or Services

1. A payer shall not deny payment for provided treatment or services solely because the guidelines do not address the requested treatment or services.

2. A payer shall not deny payment for provided treatment or services supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a medical contraindication or significant medical reason not to pay for the treatment or services.

3. A dispute related to a payer's failure to pay for provided treatment or services may be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by an injured employee.

I. A payer may reverse its decision to deny treatment/services at any time throughout this process. In this situation, the payer's subsequent authorization or agreement to pay for the treatment/services at issue will end this process.

J. A payer may issue a decision approving or denying a request for pre-authorization in whole, or in part.

K. A payer's failure to comply with the required time limits of this process may be considered unreasonable delay under A.A.C. R20-5-163.

II. <u>Payer Decision and Reconsideration of Request for Pre-Authorization</u>

A. No pre-authorization is required under the Act to ensure payment for reasonably required medical treatment or services. While pre-authorization is not required under the Act, a provider has the option to seek pre-authorization.

B. Request for Pre-Authorization

1. A provider shall submit a request for pre-authorization in writing, which must comply with the requirements set forth in Appendix A.

2. If a payer fails to communicate to a provider its decision on request for pre-authorization within 10 business days, then the payer's failure to take action is deemed a "no response" and

the provider or injured employee may submit a request for administrative review directly to the Commission as provided in Section III.

C. Payer Decision

1. Except as provided in paragraph 3 of this subsection, a payer shall communicate to the provider its decision on a request for pre-authorization no later than 10 business days after the request is received. This decision shall comply with the requirements set forth in Appendix B. For purposes of this provision, the 10 business days begins to run the day after the payer receives the request.

2. If a payer receives a request for pre-authorization that fails to meet the requirements of Appendix A, the payer may, in its discretion:

   a. Act on the incomplete request for pre-authorization; or
   b. No later than 10 business days after the request is received, notify the provider that the request for pre-authorization is incomplete.

3. If, no later than 10 business days after a request for pre-authorization has been received, a payer provides notice to the provider that an IME has been requested under A.A.C. R20-5-114, then the payer's decision on a request for pre-authorization shall be issued no later than 10 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the report.

4. Unless the decision was supported by an IME or otherwise falls within subsection I.G.2, an injured employee or provider may seek reconsideration of a payer decision by submitting a written request to the payer or identified review organization that states the specific reason(s)/justification to support the request. If not previously provided, supporting medical documentation should be included with the written request.

5. An injured employee may seek review of a payer decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).

6. Unless the decision was supported by an IME, an injured employee or provider may seek review of a payer decision issued under subsection I.G.2 by requesting administrative review by the ICA as provided in Section III.

C. Payer Reconsideration

1. Payer Review

a. Except as provided in paragraph b of this subsection, a payer shall communicate to the provider its decision on a request for reconsideration no later than 10 business days after the request is received. This decision shall comply with the requirements set forth in Appendix C. For purposes of this subsection, the 10 business days begins to run the day after the payer receives the request for review.

b. If, no later than 10 business days after a request for reconsideration has been received, a payer provides notice to the provider that an IME has been requested under A.A.C. R20-5-114, then the payer's decision on a request for reconsideration shall be issued no later than 10 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the report.

2. ICA Review of Payer Decision

a. An injured employee or provider may seek review of a payer decision by requesting an administrative review by the ICA as provided in Section III unless the payer decision was supported by an IME.

b. An injured employee may seek review of a payer decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).

c. If a payer fails to respond to a request for reconsideration within 10 business days, the provider or injured employee may submit a request for administrative review directly to the Commission as provided in Section III.

III. ICA Administrative Review

A. This administrative review process is limited to requests for medical treatment or services related to the management of chronic pain or the use of opioids for all stages of pain management.

B. A request for administrative review must be in writing and comply with the requirements set forth in Appendix D.

C. The ICA shall expeditiously provide notice to the payer that a request for administrative review has been received with instructions on how to participate in the process.

D. The ICA shall determine whether a request for administrative review is appropriate. If the ICA determines that the request falls outside the scope of this process, then the ICA shall send notice to the injured employee and the payer that the process does not apply.

E. The ICA shall issue a determination on the request, but may contract with a third party ("contractor") to provide the review, who shall be URAC accredited.

F. The payer shall pay for the costs of the third party review.

G. The administrative review conducted under this Section shall consist of a records review, and where necessary, a peer review as described below. To assist in this review, the ICA or its contractor may request or receive additional information and documentation from the provider, injured employee, or payer.

H. The parties shall cooperate and provide the ICA or its contractor with any necessary medical information, including information pertaining to the payer's decision. This information and the determination issued by the ICA shall become a part of the ICA claims file for the injured employee.

I. Before the ICA issues a determination denying the request for treatment or services, a good faith effort shall be made to conduct a peer review with the provider requesting authorization to perform the treatment or services.

J. Peer Review Requirements:

1. The individual conducting the peer review shall:

   a. Hold an active, unrestricted license (or certification) to practice medicine (or health profession) and be involved in the active practice of medicine (or health profession) during the 5 preceding years. "Active practice" is defined as performing patient care for a minimum of 8 hours per week in one of the 5 preceding years;

   b. Be licensed in Arizona, unless the ICA or its contractor is unable to find such an individual, in which case the peer review may be conducted by an individual who is licensed in another state of the United States and who meets the other requirements of this section;

   c. For a review of a request from an allopathic or osteopathic physician, nurse practitioner, physician assistant, or other mid-level provider, hold a current certification by a recognized American Board of Medical Specialty or American Osteopathic Board of Medical Specialty in the area or areas appropriate to the condition, procedure or treatment under review;

   d. Be in the same profession and the same specialty or subspecialty as typically performs or prescribes the medical procedure or treatment requested.

   e. Make a good faith effort to contact the provider requesting the pre-authorization. This good faith effort shall include making telephone contact during the provider's normal

business hours and offering to schedule the peer review at a time convenient for the provider.

K. A provider may bill the payer for time spent participating in a peer review. (*this needs to be addressed in the fee schedule*).

L. The ICA shall issue a written determination that contains the name(s) and title(s) of the person(s) (whether ICA or contractor) that conducted the review and include the following information:

1. Whether the request for treatment or services is authorized or denied (in whole or in part);

2. The information reviewed;

3. The principle reason for the decision; and

4. The clinical basis/rationale for the decision.

M. An interested party dissatisfied with the administrative review determination may request that the dispute be referred to the ICA Administrative Law Judge Division for hearing. This request for hearing shall:

1. Be in writing;

2. Filed no later than 10 business days after the administrative review determination is issued; and

3. State whether the party requests to participate in the Fast Track ALJ Dispute Resolution Program by stipulation, or declines to participate in the Fast Track ALJ Dispute Resolution Program.

N. If a timely request for hearing is filed, the administrative review determination is deemed null and void and shall serve no evidentiary purpose.

IV. Hearing Process

A. A referral of a request for hearing under subsection M of Section III shall be processed and heard in the regular manner, unless both parties agree to participate in the fast track process. The following applies only to the Fast Track ALJ Dispute Resolution Program:

1. Parties must agree to participate in the Fast Track Administrative Law Judge Dispute Resolution Program with the understanding that a short form decision will be issued.

2. Review will be limited to the treatment or service dispute(s) considered at the administrative review.

3. The Notice of Hearing will be issued within ten business days of receipt of request for hearing and agreement by both parties to participate in Fast Track program.

4. Every effort will be made to hold the hearing held within 30 calendar days from the day the Notice of Hearing is issued.

5. Discovery is limited to five interrogatories; no depositions are permitted.

6. All lay witness testimony will be taken at the time of the hearing; no further hearings will be held.

7. Medical evidence considered will be by reports only; no live medical testimony will be taken.

8. Medical file review opinions are deemed to constitute substantial evidence.

9. All documentary evidence must be submitted no later than 10 business days before the scheduled hearing.

10. The hearing will be recorded, but not transcribed unless appealed.

11. The Administrative Law Judge will issue a short form decision within five business days after the matter is deemed submitted.

Appendix A

Provider Request for Pre-Authorization Requirements

A. A provider shall include the following information with a written request for authorization to provide treatment or services:

1. Patient information (including date of injury, date of birth, and carrier claim number);

2. Diagnosis/ICD code;

3. Date of request;

4. Type of request (Initial, Routine, Urgent, or Life Threatening);

5. A statement of the treatment or services requested. Where appropriate, information about quantity, strength, and duration/frequency should be included. Use of the applicable codes should also be included and will facilitate the process; and

6. Documentation, if not already provided, that supports the medical necessity and appropriateness of the treatment or services requested (such as office notes and diagnostic reports).

B. The provider may submit the request by mail, electronically or by fax.

Appendix B

Payer Decision on Request for Pre-Authorization Requirements

A. A payer shall include the following information in its written decision to approve or deny the request for pre-authorization to provide treatment or services:

1. The date on which the request for authorization was received;

2. Patient information (including date of injury, date of birth, carrier claim number and ICA claim number);

3. The date on which an IME was completed (if applicable);

4. A statement of what has been authorized, including if applicable, a partial authorization;

5. A statement of explanation if the request for pre-authorization is denied in whole, or in part, which should include the medical reason supporting the payer's decision (e.g. treatment guideline applicability):

6. A statement of the process under which a provider or injured employee may request reconsideration or review of the payer's denial, in whole or in part, of a request for authorization, which shall include the following information:

    a. For a decision that is issued without obtaining an IME that is not subject to subsection I.G.2,

    "If you wish to request reconsideration of the decision regarding your request for authorization to provide treatment or services, you must send a written request for reconsideration to:

    Payer or identified review organization (address, phone, fax, email)

    You must include the specific reason(s)/justification to support your request. Please include additional supporting medical documentation if not previously provided."

    b. For a decision that is supported by an IME,

"If you wish review of the decision regarding your request for authorization to provide treatment or services, then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J)."

c. For a decision that is issued without obtaining an IME that is subject to subsection I.G.2

If you disagree with this decision and wish to request review by the Industrial Commission of Arizona, then you may submit a request for administrative review under (insert applicable reference) to:

Industrial Commission of Arizona
Attn: ----------
Address
ICA Telephone No

This request should be filed promptly and include the following information: Patient information (e.g. name, address, carrier claim number, and ICA claim number, date of injury, etc.); Diagnosis/ICD code Employer/Insurance Carrier/TPA information; Provider information; Information pertaining to request for treatment (e.g. request(s) and/or justification for treatment, applicable treatment guideline(s)), and denial of treatment by payer; Copies of relevant medical information or records, and; Whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

B. A payer shall provide a copy of its written decision to deny to the injured employee.

Appendix C

Payer Reconsideration Decision Requirements

A. A payer shall include the following information in its written decision to approve or deny (in whole or in part) a request for reconsideration of a denial of pre-authorization:

1. The date on which the request for reconsideration was received;

2. Patient information (including date of injury, date of birth, carrier claim number and ICA claim number);

3. The date on which an IME was completed (if applicable);

4. A statement of what has been authorized, including if applicable, a partial authorization;

5. A statement of explanation if the request for treatment is denied in whole, or in part; and

6. A statement of the process under which a provider or injured employee may request ICA review of the payer's denial, in whole or in part, of a request for pre-authorization, which shall include the following information:

    a. For a reconsideration decision that is issued without obtaining an IME,

    If you disagree with this reconsideration decision and wish to request review by the Industrial Commission of Arizona, then you may submit a request for administrative review under (insert applicable reference) to:

    Industrial Commission of Arizona
    Attn: ----------
    Address
    ICA Telephone No

    This request should be filed promptly and include the following information: Patient information (e.g. name, address, carrier claim number, and ICA claim number, date of injury, etc.); Diagnosis/ICD code Employer/Insurance Carrier/TPA information; Provider information; Information pertaining to request for treatment (e.g. request(s) and/or justification for treatment, applicable treatment guideline(s)), and denial of

treatment by payer; Copies of relevant medical information or records; Copies of relevant documentation related to payer reconsideration decision, and; Whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

b. For a reconsideration decision that is supported by an IME,

"If you disagree with this reconsideration decision and wish review by the Industrial Commission of Arizona, then the injured employee is required to file a request for investigation under A.R.S. 23-1061(J)."

B. A payer shall provide a copy of its written reconsideration decision to deny to the injured employee

Appendix D

Provider or Injured Employee Request for ICA Administrative Review Requirements

A. A request for ICA administrative review must be in writing and include the following information:

1. Patient information (e.g. name, address, ICA claim number, date of injury of the injured employee, etc.);
2. Diagnosis/ICD code;
3. Employer/Insurance Carrier/TPA information;
4. Provider information;
5. Information pertaining to request for treatment (e.g. request(s) and/or justification for treatment, applicable treatment guideline(s)), and if applicable, denial of treatment by payer);
6. Copies of relevant medical information or records;
7. Copies of documentation related to the payer's decision or non-response ; and
8. Whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition.